

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027379

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 873

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

15117

2. 51172

3

4 1

5 2

6

7 1

8 2

9 422.1

10

11

12 860

13 1-0

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

W.B. Ray, M.D. MEDICAL CERTIFICATION

FILED JUL 24 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in 1b 3 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Parkview Nursing Home 1212 Dewey Ave.		d. STREET ADDRESS (If outside, give location) 417 No. 10th St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GRACE MADGE TAYLOR		4. DATE OF DEATH Month Day Year July 14 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1886
9. AGE (last birthday) 77		IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Humeston, Iowa		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME M. E. Downs		13b. MOTHER'S MAIDEN NAME Martha Richard	
14. NAME OF HUSBAND OR WIFE John H.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Miller Funeral Home, Donnelson, Iowa	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 7-4-63 to 7-14-63 and last saw her alive on 7-13-63 Death occurred at 1:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) W.B. Ray, M.D.	
22b. ADDRESS 2605 Fremont St Joseph, Mo.		22c. DATE SIGNED 7-19-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/14/1963	23c. NAME OF CEMETERY OR CREMATORY Miller Funeral Home	23d. LOCATION (City, town, or county) (State) Donnelson, Iowa
24. FUNERAL DIRECTOR Address Heaton-Bowman St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. July 20, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

018180-049

CODE

APR 1 1963

STATEMENT BY LICENSED EMBALMER

Permit License 7-14-63

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by ELDON NORRIS, Student Embalmer No. 700

working under my personal supervision.

Student Eldon Norris
Signature of Student Embalmer

Signed William J. [Signature]

Licensed Embalmer No. 4535

P.O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.